Save with the ConnectiCare Vision Discount & Reimbursement Program

ConnectiCare covers your annual eye exam and medical treatments related to your sight. But did you know that you can also get discounts of 25% to 30% through our Vision Discount program? On top of that, we'll reimburse you up to $200 every 24 months for any combination of vision care purchases.

Make sure that your optician participates in our Vision Discount Program looking for this  using the "Find a Doctor" tool at **connecticare.com.**

Eyewear	Discounts	Reimbursement
Prescription lenses with frames **Lens options include:** • Polycarbonate • Scratch-resistant coating • Ultra-violet coating • Anti-reflective coating • Solid tint/gradient/photochromic	25% discount if you spend $250 or less; 30% discount over $250	**$200 reimbursement** Every 24 months when you mail the form on back along with all your receipts for vision materials. (Remember to keep copies for your records.)
Prescription contact lenses* • Hard or soft contact lenses • Initial disposable contact lenses (applies to first-time lens wearers only)	25% discount if you spend $250 or less; 30% discount over $250	
Associated professional services (i.e. fittings)	25% discount	
Additional coverages		
Sunglasses • Prescription • Non-prescription	25% discount	
Replacement lenses/frames	25% discount	

*Discount only available if required professional services for fittings and follow-up are purchased.

If you have questions about the Vision Discount & Reimbursement Program, please call us toll-free at

1-800-251-7722 (TTY/TDD 1-800-833-8134)
8 a.m. to 6 p.m. weekdays (Fridays until 5 p.m.).

ConnectiCare®
You know us by ♥.

Vision Materials Reimbursement Request

Please use this form if you are seeking reimbursement for purchased eyewear, such as frames, lenses or contact lenses paid out of your own pocket. This form is not for eye exam expenses. Remember you can be reimbursed up to $200 every 24 months. Please submit this form within 180 days of your eyewear purchase to receive reimbursement.

Patient's Name _____
Last Name, First Name

ConnectiCare ID # _____

Member's Name _____
Last Name, First Name/Phone

Member's Address

_____
No. Street

_____
City State Zip Code

Patient's Relationship to Member ◯ Self ◯ Spouse ◯ Child ◯ Other

Date(s) of Service _____

Doctor's Name _____ **Doctor's Phone** _____
Last Name, First Name

Doctor's Address

_____
No. Street

_____
City State Zip Code

Total Amount Paid $ _____

Services ◯ Frames ◯ Lenses ◯ Contacts

Send this completed form AND all your receipts to:

ConnectiCare, Inc. & Affiliates
Attn: Vision Benefit
P.O. Box 546
Farmington, CT 06034-0546

ConnectiCare®
You know us by ♥.